Ohio’s Diabetes and Hypertension Quality Improvement Project

Cohort #1 Kick-Off
June 4th, 2019
10:00am – 1:00pm
Kick-Off Outline

I. Introductions
II. Project overview
III. Deliverables & timeline
IV. Expectations & payment
V. Quality improvement methodology
VI. Project evaluation with Professional Data Analyst, Inc (PDA)
VII. Review next steps
VIII. Organizational assessment, lunch, and open discussion
## Project Teams

<table>
<thead>
<tr>
<th>OACHC Team</th>
<th>Title</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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<thead>
<tr>
<th>ODH Team</th>
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<tbody>
<tr>
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<tr>
<th>PDA Team</th>
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<tbody>
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</tbody>
</table>
# Participating Organizations & Improvement Project Leads

<table>
<thead>
<tr>
<th>Organization</th>
<th>Lead</th>
<th>Lead Email</th>
</tr>
</thead>
<tbody>
<tr>
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CDC Chronic Disease Funding

1815: Support state investments in implementing and evaluating evidence-based strategies to prevent and manage cardiovascular disease (CVD) and diabetes in high-burden populations/communities

- Funding period: September 30, 2018 - June 29, 2023
- Prediabetes/diabetes/hypertension/blood cholesterol
- Statewide efforts with focus on high-burden populations
QI Project

- Contract Start: April 2019
  - Year 1: Planning & FQHC Recruitment
  - Years 2-3: Implementation – Cohort #1
  - Years 4-5: Implementation – Cohort #2

- QI Project will address:
  - Prediabetes
  - Diabetes
  - Undiagnosed hypertension
  - Hypertension/High blood cholesterol
  - Medication Therapy Management (MTM)
  - Linkage to community resources

OACCHC

ohiochc.org
Objectives

► Decrease the number of adults with diabetes with a hemoglobin A1c >9
► Increase the number of adults with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved a 5-7% weight loss
► Increase control among adults with known high blood pressure and high cholesterol
► Identify patients with undiagnosed hypertension
Benefits of Participation

- Contribute to Ohio’s efforts to improve the management of adult patients with hypertension, find adult patients with undiagnosed hypertension, and identify adult patients with prediabetes
- Increase engagement and training of non-physician team members in hypertension and diabetes management
- Increase patient use of self-monitoring blood pressure
- Increase screening to all adults patients for prediabetes using a universal screening tool
- Optimize workflows for all pathways
Project Pathways
Pathways

- Implement a diabetes and hypertension/high blood cholesterol QI project with FQHCs utilizing six pathways:
  1. Screening, testing, and referring for prediabetes
  2. Management of patients with diabetes including referral to DSMEs
  3. Identifying undiagnosed HTN
  4. Management of patients with HTN/high blood cholesterol
  5. Establishing or expanding MTM services
  6. Linking patients to community resources to improve management
Prediabetes Pathway

1. Screen, Test, and Refer for Prediabetes

- Universal Screening
- Diagnostic Test
- Assign ICD10 Code: R73.03
- Document Feedback from DPP Referral
- Refer to a Local DPP
- Develop/Run Registry Report of Prediabetes Dx.
- Patient Follow-up on Registry Report

[ohiochc.org]
# Prediabetes Risk Test

**National Diabetes Prevention Program**

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<th>Height (in.)</th>
<th>Weight (lbs.)</th>
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</tr>
<tr>
<td>4’11”</td>
<td>126-147</td>
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<tr>
<td>5’0”</td>
<td>128-152</td>
</tr>
<tr>
<td>5’1”</td>
<td>132-157</td>
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<tr>
<td>5’2”</td>
<td>136-162</td>
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<tr>
<td>5’3”</td>
<td>141-168</td>
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<tr>
<td>5’4”</td>
<td>145-173</td>
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<td>5’8”</td>
<td>164-196</td>
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<tr>
<td>5’9”</td>
<td>169-202</td>
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<td>174-206</td>
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<td>179-214</td>
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<td>6’1”</td>
<td>189-226</td>
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<td>6’2”</td>
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<td>200-239</td>
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<tr>
<td>6’4”</td>
<td>205-245</td>
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<tr>
<th>Total weight category</th>
<th>1 Point</th>
<th>2 Points</th>
<th>3 Points</th>
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<tr>
<td>You weigh less than the 1 Point column (3 points)</td>
<td></td>
<td></td>
<td></td>
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If you scored 5 or higher

You are at increased risk for having prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition in which blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes. Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latino Americans, American Indians, and Pacific Islanders.

Higher body weight increases diabetes risk for everyone. Asian Americans are at increased risk for type 2 diabetes at lower weights (about 15 pounds lower than weights in the 1 Point column).

You can reduce your risk for type 2 diabetes

Find out how you can reverse prediabetes and prevent type 2 diabetes through the CDC-recommended lifestyle change program at [https://www.cdc.gov/diabetes/prevention/changeworkprogram](https://www.cdc.gov/diabetes/prevention/changeworkprogram).

Optimize your EHR to prevent type 2 diabetes

Below you will find suggestions and guidance on how to use your electronic health record (EHR) and technology to improve the care you provide patients with prediabetes. Implementing these recommendations will vary depending on which EHR system (and/or version of that system) you use. You may need to share this information with others in your health care organization to determine how best to use your EHR for diabetes prevention.

Population health tools

Screening and diagnosis reports
Generate reports to share with care teams and providers that track patients who are due for abnormal glucose screening to target via patient outreach or during patient encounters.
- These reports should be based on an evidence-based guideline or screening protocol—your institution can create its own protocol or use any established clinical practice guidelines.

Management reports
Generate reports to share with care teams and providers that identify patients who are eligible for prediabetes management (e.g., refer to a CDS-recognized organization offering the National Diabetes Prevention Program). If the patient is recommended to the CDS recognized certification program or referred for medical nutrition therapy, track target via patient outreach or during patient encounters.
- These reports can be based on available laboratory testing results.
- Reports can also be used to monitor individual patients or the entire office setting.

Provider or clinic dashboards
If your organization uses a dashboard for quality measures, consider incorporating visualizations for abnormal glucose screening and/or prediabetes management. You can create individualized provider dashboards, as well as aggregate-level institutional dashboards to provide feedback to clinical care teams and providers.

Clinical decision support

Point-of-care advisories
Develop point-of-care advisories that notify clinical care teams and providers if a patient is eligible for abnormal glucose screening or prediabetes management during a patient encounter. Ideally, the advisory will link to a referral order set.
- Example: A patient who meets United States Preventive Services Task Force criteria for abnormal glucose screening or prediabetes management will be identified in the EHR. The advisory will then be triggered and prompt the provider to access an order set with the appropriate laboratory testing orders (e.g., fasting plasma glucose), the appropriate CDS codes.

Office encounter templates
Consider incorporating questions that assess risk and eligibility for abnormal glucose laboratory testing or prediabetes management into standard encounterQuestionnaires. These can be linked to alerts and order sets that prompt providers to take appropriate action, such as a laboratory test or follow-up on a patient’s progress on lifestyle change.

Patient portal

Screening and diagnosis
Develop standard patient portal messages to remind patients that they are due for abnormal glucose screening and to prompt patients to obtain laboratory testing prior to an appointment.
- Incorporate the OhioCHC.org prediabetes risk assessment into the patient portal to engage patients in determining their risk for prediabetes (and undiagnosed type 2 diabetes).
- Incorporate abnormal glucose screening into the health maintenance or preventive care features of the patient portal.

Management

Develop portal patient messages to educate patients about their prediabetes diagnosis and for outreach to patients to discuss possible management options, e.g., referral to a CDS-recognized organization offering the National DPP lifestyle change program.
- Develop automated reminder follow-up messages to patients after a preventive service has been ordered, e.g., to alert patients to obtain a laboratory test for monitoring.

Develop and incorporate standard patient education materials and/or instructions regarding how to obtain preventive services to incorporate into patients after visit summaries.

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Diabetes Pathway

2. Management of Patients with Diabetes

- Locate DSME Program
- Best Workflow for Referral
- Referral Data to Send to DSME
- Refer Newly Diagnosed Patients
- Document Feedback from DSME Referral
- Refer Newly Diagnosed Patients
- Develop/Run Registry Report of Diabetes Dx.
- Patient Follow-up on Registry Report

ohiochc.org
**Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes:**

**ALGORITHM ACTION STEPS**

<table>
<thead>
<tr>
<th>AT DIAGNOSIS</th>
<th>ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND BEHAVIORAL NEEDS</th>
<th>WHEN NEW COMPLICATING FACTORS INFLUENCE SELF-MANAGEMENT</th>
<th>WHEN TRANSITIONS IN CARE OCCUR</th>
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<tbody>
<tr>
<td>- Answer questions and provide emotional support regarding diagnosis</td>
<td>- Assess all areas of self-management</td>
<td>- Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals</td>
<td>- Develop diabetes transition plan</td>
</tr>
<tr>
<td>- Provide overview of treatment and treatment goals</td>
<td>- Review problem-solving skills</td>
<td>- Discuss impact of complications and successes with treatment and self-management</td>
<td>- Communicate transition plan to new health care team members</td>
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<tr>
<td>- Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines)</td>
<td>- Identify strengths and challenges of living with diabetes</td>
<td>- Establish DSME/S regular follow-up care</td>
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<tr>
<td>- Identify and discuss resources for education and ongoing support</td>
<td>- Make reference to DSME/S and medical nutrition therapy (MNT)</td>
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**DIABETES EDUCATION: AREAS OF FOCUS AND ACTION STEPS**

- Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how:
  - Medications – choices, action, arrhythmia, side effects
  - Monitoring blood glucose – when to test, interpreting and using glucose pattern management for feedback
  - Physical activity – safety, short-term vs. long-term goals/recommendations
  - Preventing, detecting, and treating acute and chronic complications
  - Nutrition – food plan, planning meals, purchasing food, preparing meals, portioning food
  - Risk reduction – smoking cessation, foot care
  - Developing personal strategies to address psychosocial issues and concerns
  - Developing personal strategies to promote health and behavior change

- Review and reinforce treatment goals and self-management needs
- Emphasize preventing complications and promoting quality of life
- Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands
- Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes
- Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications
- Provide/refer for emotional support for diabetes-related distress and depression
- Develop and support personal strategies for behavior change and healthy coping
- Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change
- Identify needed adaptations in diabetes self-management
- Provide support for improved self-management skills and self-efficacy
- Identify level of significant other involvement and facilitate education and support
- Assist with facing challenges affecting level of activity, ability to function, health benefits and feelings of well-being
- Maximize quality of life and emotional support for the patient (and family members)
- Provide education for others now involved in care
- Establish communication and follow-up plans with the provider, family, and others

Source: [https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorithm_action_steps.pdf](https://professional.diabetes.org/sites/professional.diabetes.org/files/media/algorithm_action_steps.pdf)
Undiagnosed Hypertension Pathway

3. Identifying Undiagnosed Hypertension

Ensure ALL Staff are Trained in BP Measurements

Identify Undiagnosed HTN Patients via EHR

Workflow for Running the EHR Report

Develop/Run Registry Report of HTN Dx.

Assign Diagnosis of HTN if Meet Criteria

Patient Follow-up on Registry Report

ohiochc.org
Ohio Academy of Family Physicians- How to Appropriately Measure Blood Pressure in a Practice Setting

Source: https://www.youtube.com/watch?v=-LqKmMaHsk&feature=youtu.be
PLANK 1

Direct Care Staff Trained in Accurate BP Measurement

All team members involved in direct patient care should be trained in taking blood pressures according to a standard process. An annual evaluation/verification should involve both the ability to follow the process and the accuracy of blood pressure measurements. The entire on-site team should, through training, be aware of the importance of hypertension management and target blood pressures.

Retraining and evaluation on blood pressure measurement technique should be required at least annually, including assessment of blood pressure measurement competency through:

- Knowledge of proper technique and different types of observer bias
- Process to properly maintain and calibrate equipment
- Interpretation of measurements including understanding of the variability of blood pressure depending on time of day, exercise, and timing of medications
- Demonstration of accurate technique of patient positioning, selection of cuff size, obtaining a valid blood pressure measurement, recording it accurately, and reporting abnormal results

Tips for Obtaining Accurate Blood Pressure Measurement:

1. Ask if the patient avoided caffeinated beverages and smoking for at least 30 minutes before the examination.
2. Have the patient sit calmly for five minutes with back supported and feet flat on the floor.
3. Patient's arm should be bare. Cuff may be applied over a smoothly rolled-up sleeve, provided there is no tourniquet effect.
4. Support the patient's arm on a firm surface at heart level, slightly flexed at elbow.
5. Both the healthcare team member and the patient should refrain from taking white BP is measured.
6. Use appropriate cuff size. The inflatable part should be long enough to encircle at least 80% of arm and wide enough to encircle 40% of arm at mid-point. When in doubt, select the larger size.

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<th>RECOMMENDED CUFF SIZES</th>
<th>ADULT (S)</th>
<th>ADULT (L)</th>
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<tr>
<td>Small (Child) 22 to 24 cm</td>
<td>Small</td>
<td>Adult (L)</td>
</tr>
<tr>
<td>Small (Child) 24 to 27 cm</td>
<td>Medium (M)</td>
<td>Adult (L)</td>
</tr>
<tr>
<td>Small (Child) 27 to 29 cm</td>
<td>Large (XL)</td>
<td>Adult (XL)</td>
</tr>
<tr>
<td>Small (Child) 29 to 32 cm</td>
<td>Extra Large (XXL)</td>
<td>Adult (XXL)</td>
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</table>

7. Wrap the cuff snugly around bare upper arm. The lower edge should be centered two fingers width above the bend of the elbow, and the middle of the bladder should be over the brachial artery pulsation.
8. The aneroid dial or mercury column should be clearly visible and facing you.
9. Using light pressure, position stethoscope over brachial artery and not touching the cuff.
10. "Round numbers" are not acceptable - measure and record to the nearest 2 mm Hg.

### CHANGE CONCEPTS | CHANGE IDEAS | TOOLS AND RESOURCES
---|---|---
Develop HTN screening and diagnosis policy and protocol (includes elevated blood pressure confirmation approach) | • Appendix C: HIPS Strategy, Le Masatre Community Health Center | 
Develop a potentially un hypertensive proactively | • Appendix D: Screening and Diagnosing Hypertension, Grace Community Health Center | 
Implement a Policy and Process to Screen Every Patient for Elevated BP and Undiagnosed HTN at Every Visit | • Appendix E: Protocol for Elevated Blood Pressure in Medical Visits | 
Configure EI warning to normal range | | 
Configure BI warning to normal range | | 

**NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS**

**Million Hearts: Leveraging Health Information Technology (HIT), Quality Improvement (QI), and Primary Care Teams to Identify Hypertensive Patients Hiding in Plain Sight (HIPS)**

**Consolidated Change Package – June 30, 2015**

This change package is a deliverable of the NACHC Million Hearts HIPS Project. It was produced by reviewing the details of the change ideas each health center team employed and any associated tools and resources; this document is a compilation of items thought to be most valuable and that most clearly capture the best that emerged from this work. The change package structure and organization aligns with the CDC’s [Worksheets](http://mylearning.nachc.com/diweb/fs/file/id/229350) used to map and identify enhancements to workflows around identifying potential undiagnosed hypertension, engaging patients in care, and diagnosing hypertension in a timely and accurate manner. Those three steps are critical precursors to managing hypertension successfully and achieving blood pressure control. This change package also aligns with the CDC/Million Hearts Hypertension Control Change Package.

Change concepts and ideas are organized into key foundations, population health management, and individual care steps, with the titles of associated tools and resources indicated next to specific change ideas they support. The term “HIPS patients” used throughout the document, refers to patients who met the criteria established in this project to identify a patient with potentially undiagnosed hypertension.

### TABLE 1. KEY FOUNDATIONS

<table>
<thead>
<tr>
<th>CHANGE CONCEPTS</th>
<th>CHANGE IDEAS</th>
<th>TOOLS AND RESOURCES</th>
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<tbody>
<tr>
<td>Make Identification and Diagnosis of HTN a Practice Priority</td>
<td>Designate an HTN Champion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure Care Team Engagement in HTN Screening and Diagnosis</td>
<td>• Appendix A: Health Center Staff Engagement Material – Hiding in Plain Sight (HIPS), Grace Community Health Center</td>
</tr>
<tr>
<td></td>
<td>Provide BP checks without appointment or co-pay</td>
<td>• Appendix B: BP Check Visits, Golden Valley Health Centers</td>
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</table>
Hypertension/High Blood Cholesterol Pathway

4. Management of Patients with HTN/High Blood Cholesterol

- Status of Running EHR Report of HTN Patients
- Utilization of HTN EHR Report
- Team-Based Care Workflow for HTN/HBC Patients
- Ensure Patient Self-Monitoring Plan
- Schedule Patient Follow-Up as Needed
- Referral to Community-Based SMBP Programs (e.g., Y-BPSM)
The YMCA’s Blood Pressure Self-Monitoring Program is a four month program that supports participants in developing the habit of self-monitoring and identifying opportunities for action through consultations with a Healthy Heart Ambassador. The program is based on Check, Change, Control, © from The American Heart Association.

GOALS
- Better blood pressure management
- Blood pressure reduction
- Learn what triggers elevated blood pressure
- Developing healthier eating habits

BENEFITS
- Program is evidence-based and may lower blood pressure
- Provides personalized support from a Healthy Heart Ambassador during Office Hour consultations
- Heart healthy nutrition education
- Easy-to-use, portable self-tracking tool provided
- Non-YMCA Members will receive a 1 month YMCA pass and 4 sessions with a Wellness Coach

Individuals are asked to self-monitor their blood pressure at least twice a month and check in with a Healthy Heart Ambassador twice a month. Nutritional Information sessions are held once a month.

Fees include a Blood Pressure cuff provided to every participant.

YMCA OF CENTRAL OHIO
40 W Long St, Columbus, OH 43215
P: 1-833-438-1312 ymcaohio.org
F: 614-441-3293

Contact 1-833-438-1312
ymcachc.org/
blood-pressure-self-monitoring-program
# My Daily Blood Pressure and Weight Log:

<table>
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<th>DATE</th>
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<th>DAILY BLOOD PRESSURE</th>
<th>DAILY HEART RATE</th>
<th>DAILY ACTIVITIES</th>
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<td></td>
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<tr>
<td>TUESDAY</td>
<td>___ / ____</td>
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<tr>
<td>WEDNESDAY</td>
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</tbody>
</table>
MTM Pathway

5. Establishing or Expanding MTM Services

- Assess Current Pharmacy Landscape
- Availability of Clinical Pharmacy Services
- Referral Workflow to MM/Clinical Pharmacy Services
- Document Feedback from MM/Clinical Pharmacy Referral
- Patient Referral to MM/Clinical Pharmacy Services

Staff trained on providing pharmacy-based care for the underserved
Medication Therapy Management

Mission Statement
To advance the health and wellness of underserved citizens of Ohio through fostering pharmacists providing integrated medication therapy management in interprofessional, team-based care. Public, private, community, and academic entities will collaborate to provide training and resources to disseminate improved health outcomes.

CLINICAL PHARMACY
MEDICATION THERAPY MANAGEMENT (MTM)

MTM happens when a pharmacist works with a patient as well as physicians and other healthcare providers to be sure the patient gets the best use out of the medicines he/she takes. This may include reviewing all the medicines a person takes, checking how well they are working as well as side effects or drug interactions. Pharmacists may also change how, when, or what medicines a patient is using and educate the patient how to best use their medicines to improve their health.

Pharmacists can spend time with a patient with a chronic disease, such as diabetes or high blood pressure, getting to know how best to help each individual get and stay healthy. Pharmacists help patients take the right medicines at the right time, at the right dose, with individualized attention and care in combination with lifestyle choices that can improve control of chronic diseases.

Medication Therapy Management (MTM) is provided by pharmacists in a variety of ways in all different healthcare settings. Patients may receive this specialized care from a pharmacist in their local community pharmacy, in the hospital, or in a clinic or doctor’s office. The pharmacist may talk with a patient through phone calls or during scheduled visits, or he or she may touch base with a patient while they are at the pharmacy or doctor’s office for another reason. MTM involves helping patients achieve the best health possible through using the right medicines for them the right way. Pharmacists make this happen by being flexible in the way they connect and care for patients as well as being accessible in so many facets of healthcare and communities.

Source: https://www.ohiochc.org/page/MTM
Four Considerations for Implementation

1. Settings
MTM has been implemented in several settings, including federally
controlled medical homes, managed care health systems, community
primary care clinics.

2. Policy and Law-Related Considerations
MTM is currently supported under the Centers for Medicare & Medicaid
Services’ Medicare Drug Utilization Review Program (DURP) for
Medicare Part D beneficiaries. MTM is also supported under the
Centers for Medicare & Medicaid Services’ Medicare Advantage
Prescription Drug Plan (MA PDP) Program.

3. Implementation Guidance
Implementation guidance has been developed by various organizations,
including the National Coalition for Physician-led MTM, the
American Medical Association’s MTM Task Force, and the
American Pharmacist Association’s MTM Task Force.

4. Resources
Several federal agencies are working on initiatives that focus on
improving care for patients with chronic conditions, including the
Centers for Medicare & Medicaid Services, the National
Institute on Aging, the National Institutes of Health, and the
American Medical Association.

Community Pharmacists and Medication Therapy Management

Medication therapy management (MTM) is a distinct service or group of services provided
by health care providers, including pharmacists, to ensure the best therapeutic outcomes for
patients. MTM includes five core elements: medication therapy review, a personal medication
record, a medication-related action plan, intervention or referral, and documentation and
follow-up. Within the context of cardiovascular disease (CVD) prevention, MTM can include
a broad range of services, often centering on (1) identifying uncontrolled hypertension (2)
educating patients on CVD and medication therapies, and (3) advising patients on health
behaviors and lifestyle modifications for better health outcomes. MTM is especially effective
for patients with multiple chronic conditions, complex medication therapies, high prescription
costs, and multiple prescribers. MTM can be performed by pharmacists with or without a
collaborative practice agreement (CPA), and it is a strategy that can be considered to provide
both Domain 3 (health care system interventions) and Domain 6 (community-clinical links).

Summary
MTM is care provided by pharmacists with the goal of
ensuring the most effective use of drug therapy. It is a cost-
effective strategy for increasing
patient knowledge and
medication adherence and
lowering blood pressure.

Evidence of Effectiveness

Evidence of Impact

Community Resources Pathway

6. Linking to Community Resources

- Screen for Social Determinants of Health
- Maintain Resource List of Community/Social Services
- Provide Information to Patients on Community/Social Services
- Determine team member to collect and distribute information on community/social services
Food Insecurity Assessment Tool and Resource List

To help your patients and clients improve their health, it is important to understand food insecurity and provide them with resources to get more healthy food. When patients/clients and their children cannot get enough healthy food, they have food insecurity. They:

- Are at greater risk for being emotionally distressed.
- Eat less expensive foods which are often unhealthy.
- Have little choice over what kinds of food to buy or receive for free, making it difficult or impossible to eat balanced meals.
- Have periods when they don’t eat, then overeat when food is available. If they have diabetes, this makes it very difficult to manage blood sugar.
- Have a greater risk for being overweight or obese.
- Are more likely to get diseases like diabetes.

To help your patients/clients lessen food insecurity, take these three steps:

1. Read each statement* and ask your client if the statement is often true, sometimes true, rarely true, or never true.
   - Within the past 12 months, we worried whether our food would run out before we got money to buy more. [ ] Often True [ ] Sometimes True [ ] Rarely True [ ] Never True
   - Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more. [ ] Often True [ ] Sometimes True [ ] Rarely True [ ] Never True

2. If your client responds “often true” or “sometimes true” to either statement, they likely have food insecurity. Help them get more food by filling out the list of resources (see next page) and giving it to them. You can also fill out the list, make copies, and leave them in waiting rooms and other areas for community members to pick up.

3. Advocate for nourishing foods in your community. Take steps to increase the availability of nutritious, affordable food.


Where to Get Food Assistance in This Community

Community Name: __________________________ Date: ____________

Not having enough food for yourself and your family is stressful. Lack of good food makes it difficult to provide nutritious meals that help children grow and adults stay healthy. T’is thought of not having enough food can make you worry. There are resources to help. If you need food assistance, please don’t wait to contact the programs on this list. They can help you get the food you need for yourself and your family.*

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Contact Name</th>
<th>Contact Number</th>
<th>Other Important Information (Location, Who Can Qualify, Hours, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNAP - Supplemental Nutrition Assistance (Food Stamps)</td>
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<td>Food Distribution ( Commodities)</td>
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<tr>
<td>Women, Infants, and Children (WIC)</td>
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<tr>
<td>School Lunch and Breakfast Program</td>
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<tr>
<td>Summer Food Service Program for Children</td>
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<tr>
<td>Senior Center</td>
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<tr>
<td>Meals on Wheels</td>
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<tr>
<td>Tribal Food Program</td>
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<tr>
<td>Farmers Markets</td>
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<tr>
<td>Community Gardens</td>
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<tr>
<td>Food Bank / Food Pantry</td>
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<tr>
<td>“Mobile Grocery Store” Truck</td>
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<td></td>
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<tr>
<td>Church / Place of Worship</td>
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<td></td>
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<tr>
<td>Social Services</td>
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</tbody>
</table>

*Check with the program to see if you qualify to get food.

PRAPARE Implementation and Action Toolkit

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' social determinants of health, transform care to meet the needs of their patients, and ultimately improve health and reduce costs. PRAPARE is also a standardized patient risk assessment tool as well as a process and collection of resources to identify and act on the social determinants of health.

The PRAPARE Implementation and Action Toolkit is designed to provide interested users with the resources, best practices, and lessons learned to guide implementation, data collection, and responses to social determinant needs.

This is a modular toolkit. The Toolkit chapters focus on the major steps that are needed to implement a new data collection initiative on social determinants needs and circumstances. New users are advised to go through the entire Toolkit. Other users may wish to focus on certain chapters to build or enhance capacity in certain areas.

This Toolkit is based on the experiences, best practices, and lessons learned from our early adopting and pioneering health centers. We thank them for sharing their innovations and lessons learned with us so that others can advance their own social determinants of health journey.

Building off of the roots of the PRAPARE name, chapters are organized based on whether they help users a) PREPARE for social determinants data collection, b) ASSESS social determinants of health, or c) RESPOND to social determinants of health data.

Cohort #1 Deliverables
Contract Year 1 Deliverables: April 2019 – June 2019

- **Kick-Off Meeting**
  - The purpose of the kick-off meeting is to ensure that all participating FQHCs have a clear understanding of the QI project and the necessary capacity to implement the six pathways process steps
  - Topics to discuss include details and expectations, a review of evidence-based resources, materials and tools available, and an overview of the data submission requirements
  - **Meeting date:** June 4th, 2019
Contract Year 1 Deliverables: April 2019 – June 2019

- Baseline Assessment Report
  - Complete the baseline assessment report outlining current state of chronic disease management processes specific to the six pathways
  - Due date: June 4th, 2019
Quarterly Data Collection/Site Progress Report

- Provide quarterly updates on progress of contract work including, but not limited to, process and outcome measures, individual progress for each FQHC involved in the project, and data for the six pathways

- Due date: June 21st, 2019
Contract Year 1 Deliverables: April 2019 – June 2019

- **Practice Coaching Plans**
  - Collaboratively develop a broad practice coaching plan based off of each organization’s baseline assessment that addresses each of the six pathways
  - Coaching plans can include, but are not limited to, process maps, timelines, and PDSA cycles
  - **Due Date: June 28th, 2019**
Contract Year 2 Deliverables: July 2019 – June 2020

- **Quarterly Data Collection/Site Progress Report**
  - Provide quarterly updates on progress of contract work including, but not limited to, process and outcome measures, individual progress for each FQHC involved in the project, and data for the six pathways
  - Due date: September 2019, December 2019, March 2020, & June 2020
Refine Practice Coaching Plans

- Refine and adjust practice coaching plans based on need and site visits for each participating FQHC that addresses each of the six pathways
- Coaching plans can include, but are not limited to, process maps, timelines, and PDSA cycles
- Due Date: September 2019
Contract Year 2 Deliverables: July 2019 – June 2020

- **Electronic Health Record Technical Assistance**
  - Provide monthly technical assistance to participating FQHCs relating to the six pathways
  - Monthly technical assistance can include EHR user groups, workflow sharing, and population health best practices
  - **Due date: Monthly**
Contract Year 2 Deliverables: July 2019 – June 2020

- **Disseminate Information/Tools/Resources**
  - Share QI best practices, tools/resources, and/or other project related materials (e.g. data reports, biennial summary reports, etc.) with all non-project participating FQHCs using various dissemination methods (PowerPoint presentations, webinars, videos, articles, blogs)
  - **Due Date:** September 2019, December 2019, March 2020, June 2020
Contract Year 2 Deliverables: July 2019 – June 2020

- **Biennial Summary**
  - Develop and distribute a biennial summary report, including successes, challenges, barriers, lessons learned, and proposed process changes for the next contract year
  - Due Date: June 2020
Contract Year 3 Deliverables: July 2020 – June 2021

- **Quarterly Data Collection/Site Progress Report**
  - Provide quarterly updates on progress of contract work including, but not limited to, process and outcome measures, individual progress for each FQHC involved in the project, and data for the six pathways
  - **Due date: September 2020, December 2020, March 2021, & June 2021**
Contract Year 3 Deliverables: July 2020 – June 2021

- **Electronic Health Record Technical Assistance**
  - Provide monthly technical assistance to participating FQHCs relating to the six pathways
  - Monthly technical can include EHR user groups, workflow sharing, and population health best practices
  - **Due date: Monthly**
Disseminate Information/Tools/Resources

Share QI best practices, tools/resources, and/or other project related materials (e.g., data reports, biennial summary reports, etc.) with all non-project participating FQHCs using various dissemination methods (PowerPoint presentations, webinars, videos, articles, blogs)

Due Date: September 2020, December 2020, March 2021, June 2021
Contract Year 3 Deliverables: July 2020 – June 2021

- **Dissemination of Project Findings**
  - Share QI tools, resources (posters, PowerPoint presentations, etc.) and cohort #1 findings at OACHC Annual Conference
  - Due date: April 2021
Contract Year 3 Deliverables: July 2020 – June 2021

- **Year-End Report**
  - Submit a year-end report that summarizes all work performed under contract, including accomplishments, challenges, lessons learned, data trends, EHR technical assistance provided, and progress on activities outlined in the practice coaching plans.
  - **Due Date:** June 2021
Contract Years 4 & 5 Deliverables: July 2021 – June 2023

- **Quarterly Data Collection/Site Progress Report**
  - Provide quarterly updates on progress of contract work including, but not limited to, process and outcome measures, individual progress for each FQHC involved in the project, and data for the six pathways
  - Due date: September 2021, December 2021, March 2022, June 2022, September 2022, December 2022, March 2023, June 2023
Contract Years 4 & 5 Deliverables: July 2021 – June 2023

- **Final Report**
  - Develop and submit a final report that summarizes all work performed under the contract in both cohort #1 and cohort #2, including accomplishments, challenges, data, and progress on activities outlined in the practice coaching plans
  - **Due Date:** June 2023
## Timeline of Key Activities for Cohort #1

<table>
<thead>
<tr>
<th>Activity</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face Cohort #1 Kick-Off Meeting</td>
<td>June 4th, 2019</td>
</tr>
<tr>
<td>FQHC Needs &amp; Organizational Assessment</td>
<td>June 2019 – August 2019</td>
</tr>
<tr>
<td>FQHC Practice Coaching Plan Development</td>
<td>June 2019 – September 2019</td>
</tr>
<tr>
<td>Electronic Health Record (EHR) Technical Assistance</td>
<td>Monthly; June 2019 – June 2021</td>
</tr>
<tr>
<td>Ongoing Quality Improvement Activities</td>
<td>June 2019 – June 2021</td>
</tr>
<tr>
<td>Monthly Meeting &amp; Touch Base</td>
<td>October 2019 – June 2021</td>
</tr>
<tr>
<td>Diabetes Collaborative</td>
<td>Quarterly; June 2019 – June 2021</td>
</tr>
<tr>
<td>Quarterly Data Collection</td>
<td>June 2019 – June 2021</td>
</tr>
<tr>
<td>Dissemination of Quality Improvement Information, Tools, and Resources</td>
<td>Quarterly; September 2019 – June 2021</td>
</tr>
<tr>
<td>Biennial Summary of Quality Improvement Project</td>
<td>June 2020</td>
</tr>
<tr>
<td>Year-End Report</td>
<td>June 2021</td>
</tr>
<tr>
<td>Ongoing Quarterly Data Collection</td>
<td>July 2021 – June 2023</td>
</tr>
</tbody>
</table>
Expectations & Payment
FQHC Expectations

- Designate an improvement project lead to:
  - Provide day-to-day management and coordination for guiding the organization through the implementation process
  - Lead improvement team in keeping efforts on track
  - Participate in all on-site trainings and discussions, monthly webinars and/or conference calls, and meetings
  - Quarterly data collection and submission
FQHC Expectations

- Participate in quality improvement practice coaching plans for all pathways included in the project
- Support improvement work, including:
  - Staff training and education
  - Optimize workflows and processes
  - Update policies and procedures to reflect evidence-based guidelines
## FQHC Payment

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Payment</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission of subcontract agreement and participation in kick-off meeting</td>
<td>$10,000</td>
<td>July 2019</td>
</tr>
<tr>
<td>Participation in all on-site trainings and discussions, monthly webinars</td>
<td>$5,000 annually; $10,000 total</td>
<td>June 2020 &amp; June 2021</td>
</tr>
<tr>
<td>and conference calls, and meetings</td>
<td>($2 contract years)</td>
<td></td>
</tr>
<tr>
<td>Quarterly data collection and submission</td>
<td>$1,250/report; $10,000 total</td>
<td>June 2019 – June 2021</td>
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<tr>
<td></td>
<td>(8 reports)</td>
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<tr>
<td>Participation and implementation in quality improvement practice coaching</td>
<td>$5,000 annually; $10,000 total</td>
<td>June 2020 &amp; June 2021</td>
</tr>
<tr>
<td>plans for all pathways</td>
<td>($2 contract years)</td>
<td></td>
</tr>
<tr>
<td>Ongoing quarterly data collection and submission</td>
<td>$1,250/report; $10,000 total</td>
<td>July 2021 – June 2023</td>
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<td>(8 reports)</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>$50,000 per FQHC</strong></td>
<td><strong>June 2019 – June 2023</strong></td>
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</table>
Quality Improvement Methodology
Essentials

- Improvement methods: selecting, testing, and implementing changes
  - Plan-Do-Study-Act (PDSA), Lean approach, Specific-Measurable-Achievable-Relevant-Time bound (SMART), Define-Measure-Analyze-Improve-Control (DMAIC)
- Building and engaging a team
- Setting aims and establishing measures
Understanding measurement through visual improvement tools (work/project plans, process mapping, driver diagrams, cause and effect diagrams, flowcharts, run and control charts)

- Spreading changes, monitoring performance/outcomes, and sustainability
- Storyboards
Project Evaluation with Professional Data Analysts
The Ohio 1815 evaluation team

Melissa Chapman Haynes
Julie Rainey
Heather Zook
Traci Capesius
Our Clients

Tobacco control & Chronic disease prevention & management

AK  ID  MT  ND  MN  WI  IL  MI  NY  MA  OR  NV  WY  SD  IA  IN  OH  PA  NJ  CT  RI  CA  UT  CO  NE  MO  KY  WV  VA  MD  DE  AZ  NM  KS  AR  TN  NC  SC  DC  OK  LA  MS  AL  GA  HI  TX  FL
You can’t give everyone equal interventions and expect that’s going to get everyone to a better place. We’ve got to put even more effort toward those areas that are having the worst outcomes or we’re not going to correct that deficit.

-- Dr. Ted Wymyslo
Evaluation Planning
Evaluation of QI Pathways

1. Prediabetes
2. Diabetes management
3. Undiagnosed hypertension
4. Hypertension/HBC management
5. MTM
6. Community supports
What types of support/resources have your 1815-funded activities established or maintained to promote medication management for people with diabetes?

- Interviews with OACHC and FQHC staff
- Document geographic areas and priority populations reached by participating FQHCs
- Determine which pharmacists are using MTM
- Gather knowledge regarding community-based programs
To what extent has implementation of the FQHC QI Project increased the adoption of MTM between pharmacists and physicians for the purpose of managing high blood pressure, high blood cholesterol and lifestyle modification?

- Interviews with OACHC and FQHC staff
- Document of community resources available, and identify needs for expanded resources
- Determine which pharmacists are using MTM
- Establishment of baseline data from OACHC
Medication Therapy Management Survey (coming soon)
“Bridge of Dreams”

Coordination of data collection
• Baseline assessment, OACHC
• Quarterly reporting, ODH
• Facilitators and barriers, PDA

Annually, we will assess the results of the program by synthesizing this information and reporting it to CDC.
“I hope to learn _____ through participation in the QIP.”
Melissa Chapman Haynes, PhD
mchapman@pdastats.com
Next Steps

- Complete baseline organizational assessment and submit to Erica Brown today

- Submit all data points by Friday, June 21st, 2019
  - Resource: Ohio’s Diabetes & Hypertension Quality Improvement Project Quarterly Data Collection Site Progress Report
  - Email completed form to Erica Brown (ebrown@ohiochc.org)

- Schedule on-site assessment facilitation and review
  - Visits to be scheduled by August 2019
QUESTIONS?

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